CoACT Collaborative Care

Program Primer

AHS has 100,000-plus staff, physicians and volunteers—and CoACT acknowledges that if we work effectively together with patients and families, and if we harness the energy, enthusiasm and talents of our workforce, we'll be well positioned to do our very best in caring for patients, for families and for one another.

Dr. Verna Yiu
AHS President & CEO

What is Collaborative Care?

- Collaborative Care is a healthcare approach in which interprofessional teams work together, in partnership with patients/residents and families to achieve optimal health outcomes.
- Collaborative Care is grounded in three principles: patient centered care, team effectiveness and functioning and safe, high quality care delivery.
- In Alberta Health Services (AHS), Collaborative Care is our approach to providing health care services, and the CoACT Collaborative Care Framework is how Collaborative Care is advanced across the organization.
- The 30 elements of the CoACT Collaborative Care Framework detail the practices, processes, enablers and partnerships integral to advancing Collaborative Care and achieving optimal outcomes.

Key Definitions

CoACT Program

- CoACT is a program within Health Professions and Practice, reporting to the Associate Chief Nursing Officer, the CoACT Program includes the CoACT Team.
- The portfolio holds the primary administrative accountability and resources to support design, implementation and optimization of Collaborative Care uptake in AHS.

CoACT Team

- A resource, with a variety of expertise including Program Managers, Team Leads, Senior Practice Consultants, Administrative Support and Communications Coordinators, that collaboratively supports Zones and Sites to continue implementation and optimization of Collaborative Care.

Did you Know?

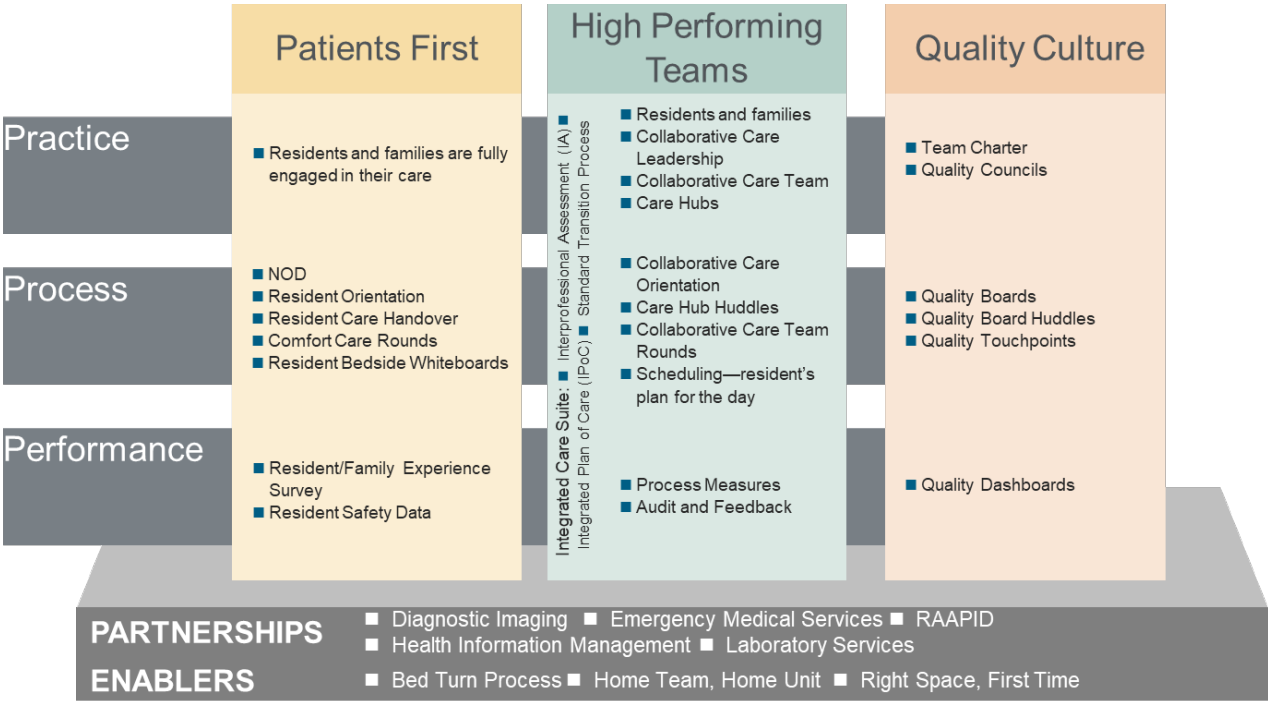
The Quality, Safety and Outcomes Improvement Executive Committee (QSO) has identified CoACT Collaborative Care as a quality improvement priority for the organization in 2018/19 and is foundational in preparing for Connect Care.

More information and resources

On Insite: insite.ahs.ca/coact | Email: CoACT@ahs.ca

Alberta Health Services | CoACT Teams in Action

The CoACT Collaborative Care Framework



The design of the CoACT Collaborative Care Framework is informed by evidence and intended to be applicable across the care continuum. The elements of the CoACT Collaborative Care Framework are inter-dependent and optimal outcomes are achieved when implemented in whole.

Outcomes and Benefits

Preliminary benefits for patients/residents, providers and the healthcare system, are supported by evidence and the CoACT Collaborative Care Evaluation Report (October 2017). The report indicated CoACT Collaborative Care influenced:

Patients First	High Performing Teams	Quality Culture
• Improved experience of patients/families • Greater inclusion and engagement of patients and families • Improved communication between patients, families, and providers.	• Improved experience of providers • Greater teamwork, communication and focus on patient-family centredness in patient care	• Improvements in selected clinical outcomes* • Strengthening units' focus on quality improvement by formalizing processes and encouraging new initiatives.

*urinary tract infection rate, in-hospital fracture rate, hospital acquired pneumonia rate, percent of alternate level of care days, crude inpatient mortality rate, ratio of acute length of stay to expected length of stay, and typical average length of stay.

Access the CoACT Evaluation Summary on Insite:
insite.ahs.ca/assets/coact/tms-coact-final-evaluation-summary.pdf

CoACT Collaborative Care Element Descriptions

Resident-facing | Team-facing | Quality Culture | Enablers

Collaborative Care Team
The entire care team, including residents and families. Inter-professional competencies are demonstrated, and high quality, proactive, integrated care meets resident needs and achieves the best possible health outcomes.

Collaborative Care Leadership
Frontline teams that support successful implementation and sustainability of Collaborative Care, and Quality Culture.

Collaborative Care Orientation
Team members receive an introduction to the Collaborative Care Framework to enable participation in Collaborative Care.

Integrated Care Process*
Care planning involves residents and families—assessments and care plans are coordinated with the entire team for safe and timely care and transitions.

*enabled by Connect Care

Intake

Right Environment, First Time
Site and service level capacity management that looks at the bed map, bed allocation and performance monitoring.

Home Team, Home Unit
Co-location of residents and providers to maximize continuity of care.

NOD
Staff say their name, occupation and duty when they introduce themselves.

Resident Orientation
Residents and families receive information on what to expect during their care experience.

Standard Transition Process
Proactively planning for transitions.

Daily Care

Care Hub
A group of healthcare providers working together to provide day-to-day direct care to a group of patients.

Care Hub Huddles
Regular touchpoints to assess and evaluate resident care needs and ensure residents receive the right care, at the right time by the most appropriate provider.

Resident Care Handover
Verbal shift handover between the outgoing and incoming Care Hub team, including the resident when possible.

Resident Bedside Whiteboard
Whiteboard that residents, families and care providers use to communicate with one another.

Comfort Care Rounds
Regular check-ins with residents to ensure they are comfortable, safe, and needs are proactively addressed.

Collaborative Care Team Rounds
Weekly scheduled time for the entire care team to meet regarding all residents to update care plans, and address needs

Scheduling—Resident's Plan for the Day
Daily coordination of team schedules, tests, and procedures to maximize efficiency and keep the resident and family informed of their daily schedule.

Day of Transition

Bed Turn Process
A standardized method to maximize efficiency in bed turnover and bed readiness.

Quality Suite

Team Charter
Description of Collaborative Care team members' responsibilities, accountabilities and working relationships in the care environment.

Quality Councils
A frontline forum to create, own and monitor real-time data to inform decision making and continuous quality improvement.

Quality Dashboards
A profile of quality measures, used to monitor performance data in support of improving patient outcomes.

Quality Boards
Visual displays of quality management activities and data focused on goals for the practice setting, program and site.

Quality Board Huddles
Collaborative Care Team gatherings at the Quality Board to discuss current quality initiatives.

Quality Touchpoints
Brief daily reviews of quality opportunities that the team is working to improve.

Partnerships

Collaborative Care includes all people and services involved in providing care. Coordination and communication between support services ensure smooth and timely care delivery.

- Diagnostic Imaging
- Emergency Medical Services
- Health Information Management
- Laboratory Services
- RAAPID
- Linen & Environmental Services
- Nutrition & Food Services
- Pharmacy Services

The CoACT Program

1 Plan and Implement

- Collaborate with operational leadership to identify scale, spread and support
- Readiness assessment of incoming units/practice settings
- Implementation planning, education and Go-Live
- Collaborative Care advocacy in operational planning and alignment
- Integration with AHS initiatives and priorities: AHS Business Plan, AHS Foundational Strategies (Patient First, People Strategy, IM/IT, RIA), Connect Care, QSO priority, etc.

2 Optimize and Sustain

- Support ongoing implementation, optimization and sustainability
- Evaluation and reporting
- Check-ins for sustainability

3 Consult

- Supporting spontaneous adoption of Collaborative Care Elements
- Ensuring access to education and support resources
- Providing consultation and advice on planning, implementation, optimization and sustainment

4 Design and Resource

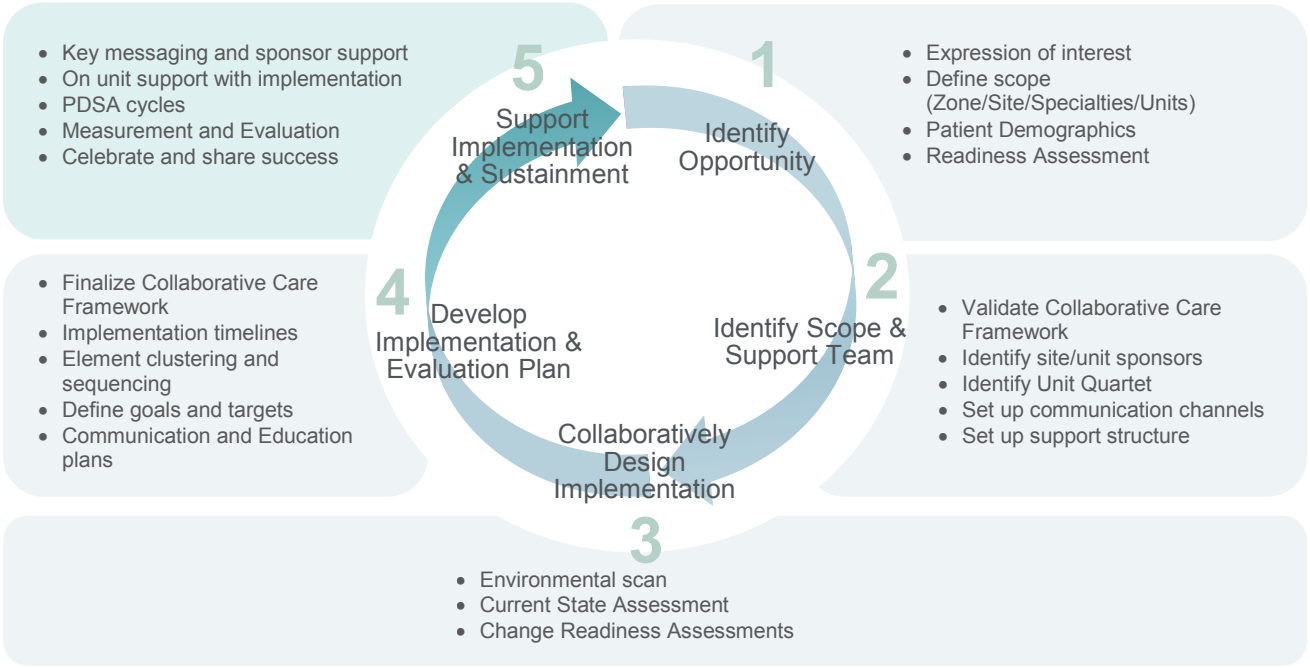
- Maintaining the CoACT Collaborative Care Framework
- Adapting the CoACT Collaborative Care Framework for specialty settings
- Reviewing and revising education resources

CoACT works closely with Connect Care teams, providing consultation and input specific to implementing Collaborative Care practices and processes.

As the provincial clinical information system is built and implemented, CoACT Collaborative Care processes inform the Connect Care design.

Implementation Process and Resources

Implementation Approach



Implementation Support Structure

We partner with supporting portfolios and groups to co-design, manage, and support Collaborative Care. This table outlines the roles and groups that are active stakeholders in, and contributors to, the process.

	Partnerships	CoACT Program Team	Operations
PROVINCIAL	Resident and Family Council Patient Safety Connect Care Human Resources Talent Management Change Management DIMR/Analytics Clinical Support Services Accreditation Integrated Quality Management Nursing Regulators Unions	Associate Chief Nursing Officer Clinical Director Senior Practice Consultants Administrative Support Program Director Program Managers: • Core Services • Interprofessional Practice Communications	Executive Sponsors
ZONE		Zone Support Teams Program Manager Senior Practice Consultant Team Lead	Zone Executive Leaders
SITE			Senior Operating Officers Program Leads
UNIT			**Unit Quartet:** Unit Lead* Unit Manager Education Lead Physician Lead

*funding provided by CoACT Program for in-scope units

More information and resources
On Insite: insite.ahs.ca/coact | Email: CoACT@ahs.ca